DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 — 0 0 3 A

2. STATE: North Dakota

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Benefits Improvement and Protection Act (BIPA) of 2000

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ budget neutral
b. FFY 2002 $ budget neutral

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, page 2, 3, 4, 5
~~Attachment 4.19-B, page 3~~
~~Attachment 4.19-B, page 4 and 5~~

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, page 2, 3, 4, 5
~~Attachment 4.19-B, page 3~~
~~New~~

10. SUBJECT OF AMENDMENT:
SMDL #01-014 Federally Qualified Health Centers and Rural Health Clinics
Disportionate share hospital payments; hospitals and out of state hospital payments

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[signature]

13. TYPED NAME:
David J. Zentner

14. TITLE:
Director, Medical Services

15. DATE SUBMITTED:
March 30, 2001

16. RETURN TO:
David J. Zentner
Director, Medical Services
ND Department of Human Services
600 E Boulevard Ave Dept 325
Bismarck ND 58505

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
March 30, 2001

18. DATE APPROVED:
6/25/01

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
1/1/01

20. SIGNATURE OF REGIONAL OFFICIAL:
[signature]

21. TYPED NAME:
Paul R. Long, MD

22. TITLE:
Acting Associate Regional Administrator

23. REMARKS:

POSTMARK: March 29, 2001

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(2) A day outlier payment is made when the length of stay for a recipient exceeds the lesser of the geometric mean length of stay plus twenty days or 1.94 standard deviations from the mean for any given DRG. Each day exceeding the threshold is paid at 60 percent of the per diem rate. The per diem rate is calculated as the hospital's basic DRG payment divided by the geometric mean length of stay.

(3) For DRG's 385-390 relating to neonates:

(a) The day outlier payment is calculated at 80% of the per diem rate once the thresholds in paragraph 2 are met; or

(b) The cost outlier thresholds are the greater of 1.5 times the DRG rate or $12,000. Costs above the threshold will be paid at 80 percent of billed charges.

(4) If the thresholds for both a cost outlier and a day outlier are met, only the day outlier payment method will apply.

g. Transfers. Payment will be the full DRG payment, inclusive of outliers, to the final hospital. Per diem payments will be made to the transferring hospitals. Total per diem payments to transferring hospitals may not exceed the full DRG payment, exclusive of outliers. Per diem is the basic DRG payment divided by the geometric mean length of stay. A patient may be transferred to another hospital and then transferred back to the original hospital which becomes the final hospital, in such case, the original hospital will not receive per diem payments but will be paid only one full DRG payment, inclusive of outliers.

2. Hospitals paid based on reasonable costs.

a. Hospitals excluded from PPS are psychiatric, rehabilitation, cancer and children's hospitals. Psychiatric and rehabilitation distinct part units are also excluded from PPS. Payments to these facilities are made based on a reasonable cost basis, using the Medicare methods and standards set forth in 42 CFR 413. An interim payment based on the Medicare cost to charge ratio will be made until such time as a cost settlement is made.

b. Indian Health Hospitals are paid inpatient per diem rates in accordance with the most recently published Federal Register notice.

3. Disproportionate Share Hospital (DSH) Adjustments.

a. Hospitals which provide services to a disproportionate share of Medicaid recipients shall receive a DSH payment subject to any limitations set forth in this section.

b. The following criteria must be met before a hospital is determined to be eligible for a DSH payment adjustment.

(1) A hospital must have:

(a) A Medicaid inpatient utilization rate of at least 1%

and at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments or payments made on behalf of Medicaid eligible recipients by managed care entities, or a low-income inpatient utilization rate exceeding 25 percent; and

(b) At least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a State Medicaid Plan. In the case of a hospital located in a rural area, (that is, an area outside of a metropolitan statistical area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures;

(2) A hospital which meets the criteria in Section 3.b(1)(a) but not 3.b(1)(b) is eligible if:

(a) The inpatients of a hospital are predominantly individuals under 18 years of age; or

(b) The hospital did not offer non-emergency obstetric services as of December 21, 1987; or

(3) A state-owned psychiatric hospital is eligible if the hospital's Medicaid inpatient utilization rate exceeds 1%.

c. The Medicaid inpatient utilization rate for a hospital shall be computed as the total number of Medicaid inpatient days and managed care inpatient days for Medicaid eligible recipients in a cost reporting period, divided by the total number of the hospital's inpatient days in the same period.

d. The low-income utilization rate is the sum (expressed as a percentage) of the fraction, calculated as follows:

(1) Total Medicaid inpatient revenues paid to the hospital, plus revenues paid to the hospital from managed care entities on behalf of Medicaid eligible recipients, plus the amount of the cash subsidies received directly from State and local governments in a cost reporting period, divided by the total amount of revenues of the hospital for inpatient services (including the amount of such case subsidies) in the same cost reporting period; and,

(2) The total amount of the hospital's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third-party or personal resources) in a cost reporting period, divided by the total amount of

the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under an approved Medicaid State Plan) that is, reductions in charges given to other third-party payers, such as HMO's, Medicare or Blue Cross.

e. A hospital which wishes to be considered for disproportionate share payments based on a low income utilization rate must submit, annually, a request indicating this desire and information sufficient to enable the computation of the low income utilization rate by April 1.

f. For the purpose of paying disproportionate share hospitals, there are three types of hospitals, hospitals paid using PPS; the state psychiatric hospital; and all other hospitals paid based on reasonable costs.

g. DSH payment adjustments are calculated as follows:

(1) Eligible hospitals paid using PPS will receive a DSH payment adjustment equal to the difference between the hospital's base DRG payment and the hospital's base DRG payment recalculated at the maximum base rate for group one plus four percent plus an additional four-tenths of one percent for each percentage point that the hospital's Medicaid utilization rate exceeds one standard deviation above the state's mean inpatient utilization rate for all PPS hospitals receiving Medicaid payments. The eligibile hospital's base DRG payment for the quarter being reported on form 64 will first be recalculated based on the maximum base rate for group one. The recalculated base DRG payment will be multiplied times the DSH adjustment percentage and that amount will be added to the difference between the hospital's base DRG payment and the recalculated base DRG payment to determine the DSH payment amount for the quarter.

(2) Eligible hospitals paid on based reasonable costs, excluding the state psychiatric hospital, will receive a DSH payment adjustment equal to $1.00 plus one-tenth of one percent for each percentage point that the hospital's Medicaid utilization rate exceeds one standard deviation above the state's mean inpatient utilization rate for all hospitals receiving Medicaid payments. The eligible hospital's actual interim payments for the quarter being reported on form 64 will be multiplied times the DSH adjustment percentage to establish the hospital's DSH payment adjustment. The DSH payment adjustment is final and no recoupment or additional payment for DSH will be made when a settlement of the interim payment to reasonable cost is made.

(3) If eligible, the state psychiatric hospital will receive a DSH payment adjustment calculated as an amount equal to $1.00 plus the state's disproportionate share allotment less the quarterly DSH payment adjustments made to all other eligible hospitals. The DSH payment adjustment to the state hospital will be made quarterly. The quarterly payment will be calculated by dividing the state's annual disproportionate share allotment by four and subtracting all disproportionate share payments made to other eligible hospitals in that quarter. Any adjustments to the state's disproportionate allotment will be corrected in the quarter the adjustment is made.

h. DSH payment adjustments will be limited as follows:

(1) Effective July 1, 1995 the DSH payment adjustment for any eligible hospital may not exceed the greater of the total of the unreimbursed costs of providing services to Medicaid recipients and of providing services to uninsured patients or the limitations set forth in section 1923(g) of the Act.

(2) If requested by the department, eligible hospitals must submit information on unreimbursed costs of providing hospital services to Medicaid recipients and of providing hospital services to uninsured patients before a DSH payment adjustment can be made.

(3) Total DSH payment adjustments paid to all eligible hospitals may not exceed the state's DSH allotment.

4. Out-of-State Inpatient Hospital Service Payments.

a. Out-of-state inpatient hospital service payments, except as identified below, shall be paid based on a percent of billed charges established by the Medicaid agency which shall not be less than 35%. The percent paid may be adjusted annually on July 1.

b. University of Minnesota Hospitals, Minneapolis, Minnesota, will be reimbursed for organ transplants based upon a payment methodology negotiated by the hospital and the Medicaid Agency.

5. Inpatient Psychiatric Services for Individuals Under 21.

a. Payments for inpatient psychiatric services for individuals under twenty-one in residential treatment centers will be made using a prospective payment system developed by the state specifically for residential treatment centers as set forth in North Dakota Administrative Code, 75-02-09.

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☐ OTHER, AS SPECIFIED:

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David J. Zentner

13. TYPED NAME:
David J. Zentner

14. TITLE:
Director, Medical Services

15. DATE SUBMITTED:
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21. TYPED NAME:
Paul R. Long, MD

22. TITLE:
Acting Associate Regional Administrator

23. REMARKS:

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

16. Payment for Case Management Services for chronically mentally ill Medicaid recipients will be based on a fee schedule developed by the agency from annual cost reports. Reported cost data will be subject to audit by the department's provider audit unit.

17. Vacated

18. Vacated

19. Certified Family Nurse Practitioners, Certified Pediatric Nurse Practitioners, and other nurse practitioners are paid at the lower of billed charges or 75% of our physician fee schedule.

20. Other Practitioner Services - For those practitioners not covered in the State Plan, payment will be based on 75% of their usual and customary billed charges.

21. Christian Science Nurses - Payment will be based on the usual and customary hourly billed charge not to exceed a maximum allowable hourly fee.

22. Christian Science Sanitoriums - Payment will be based on the rates paid by the Medicaid state agency in the state where the sanitorium is located. If no Medicaid rate has been established, payment will be based on 85% of billed charges.

23. a. Personal Care Services in-home - Payments to personal care attendants will be based on the lower of billed charges or maximum allowable fees as established for qualified service providers for the Home and Community Based Care Waiver for the Elderly and Disabled.

    b. Personal Care Services provided in settings outside the home - payments to personal care service providers will be made based on an allowable per diem rate established by the state agency.

    c. Payments for nursing services will be based on the usual and customary charges not to exceed a maximum allowable hourly fee.

24. Respiratory Care Services - Payments will be based on 75% of usual and customary billed charges.

25. Organ Transplants - Payments for physician services are based on Attachment 4.19-B No. 5 as described in this attachment. Payment for hospital services are based on Attachment 4.19-A.

30. The payment methodology for Rural Health Clinics (RHC) shall conform to section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000.

RHCs, that agree in writing to use of an alternative methodology, shall be reimbursed using an alternative PPS methodology. Provider-based RHCs shall have an alternative PPS rate established based on 100% of the RHC's billed charges, exclusive of lab charges, for the RHCs fiscal year 2000 plus the fee schedule amount for laboratory services divided by the number of visits. For free standing RHCs the Medicare maximum rate for fiscal year 2000 shall be used. The alternative PPS rate established will be adjusted annually by the Medicare Economic Index (MEI), beginning January 1, 2002. The alternative PPS rate must equal or exceed the PPS rate that would otherwise be established for the center.

The alternative PPS rate may be adjusted for an increase or decrease in the scope of services provided by the RHC. The RHC must initiate the rate change request and sufficient documentation must be submitted by the RHC to support the change in the scope of services provided.

A center which does not agree to the state's alternative payment methodology shall be reimbursed on a prospective payment system for services furnished on or after January 1, 2001 using a payment rate based on the center's reasonable costs for the center's fiscal years 1999 and 2000. Reasonable costs are costs which are related to furnishing services and do not exceed billed charges, except for costs related to laboratory services which may not exceed the Medicare fee schedule. Reasonable costs for each year are divided by the number of visits for the year and the PPS rate will be the average of the rates for the two years. The PPS rate effective January 1, 2001. The PPS rate will be adjusted on January 1 of each year by the Medicare Economic Index for primary care services and will be adjusted for any increase or decrease in the scope of services furnished by the center during the center's previous fiscal year. The PPS rate shall be payment for all Medicaid covered services and includes all costs of other ambulatory services provided in the center.

Until such time as the PPS rate is established for a RHC, interim payment for services provided after January 1, 2001 will be made using the state's payment methodology in effect on December 31, 2000. The interim rate will be adjusted to the established PPS rate and a payout for the difference will be made to the center.

In any case in which an entity first qualifies as a RHC after January 1, 2000, the rate for the first year in which services are provided, beginning on or after January 1, 2001, shall be the average rate of the 10 centers located in closest proximity to the RHC. For subsequent calendar years the rate as established shall be adjusted by the MEI and an adjustment for any increase or decrease in the scope of services furnished by the RHC in the RHC's previous fiscal year.

If services furnished by a RHC to a Medicaid eligible recipient are paid by a managed care entity at a rate less than the established rate, a supplemental payment equal to the difference between the rate paid by the managed care entity and the established rate times the number of visits shall be made quarterly.

31. The payment methodology for Federally Qualified Health Clinics (FQHC) shall conform to section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000.

FQHCs, that agree in writing to use of an alternative methodology, shall be reimbursed using an alternative PPS methodology. The alternative PPS rate shall be based on reasonable costs, exclusive of costs for other than medical visits, i.e. dental services, for the center's fiscal year 2000. The PPS rate may not exceed the maximum Medicare rate per visit for fiscal year 2000. The alternative PPS rate established will be adjusted annually by the Medicare Economic Index (MEI), beginning January 1, 2002. The alternative PPS rate must equal or exceed the PPS rate that would otherwise be established for the center.

Under the alternative methodology, the FQHC shall be reimbursed for services other than medical visits using an interim rate which will be the latest available calculated cost per visit for the additional service. The FQHC shall report annually the reasonable costs on a per visit basis for the additional services and the interim rate shall be retroactively adjusted for any increase or decrease.

The alternative PPS rate may be adjusted for an increase or decrease in the scope of services provided by the FQHC. The FQHC must initiate the rate change request and sufficient documentation must be submitted by the FQHC to support the change in the scope of services provided.

A center which does not agree to the state's alternative payment methodology shall be reimbursed on a prospective payment system for services furnished on or after January 1, 2001 using a payment rate based on the center's reasonable costs for the center's fiscal years 1999 and 2000. Reasonable costs are costs which are related to furnishing services and do not exceed billed charges, except for costs related to laboratory services which may not exceed the Medicare fee schedule. Reasonable costs for each year are divided by the number of visits for the year and the PPS rate will be the average of the rates for the two years. The established PPS rate may not exceed the average Medicare rate per visit for federal fiscal year 1999 and 2000. The PPS rate is effective January 1, 2001. The PPS rate will be adjusted on January 1 of each year by Medicare Economic Index for primary care services and will be adjusted for any increase or decrease in the scope of services furnished by the center during the center's previous fiscal year. The PPS rate shall be payment for all Medicaid covered services and includes all costs of other ambulatory services provided in the center

Until such time as the PPS rate is established for a FQHC, interim payment for services provided after January 1, 2001 will be made using the state's payment methodology in effect on December 31, 2000. The interim rate will be adjusted to the established PPS rate and a payout for the difference will be made to the center.

In any case in which an entity first qualifies as a FQHC after January 1, 2000, the rate for the first year, beginning on or after January 1, 2001, in which services are provided shall be the average rate of the state's FQHCs. For subsequent calendar years the rate as established shall be adjusted by the MEI and an adjustment for any increase or decrease in the scope of services furnished by the FQHC in the FQHC's previous fiscal year.

If services furnished by a FQHC to a Medicaid eligible recipient are paid by a managed care entity at a rate less than the established rate, a supplemental payment equal to the difference between the rate paid by the managed care entity and the established rate times the number of visits shall be made quarterly.